# HUMAN REMAINS RELEASE FORM

| FACILITY NAME: | | FACILITY ADDRESS: | | |
|---|---|---|---|---|
| DECEASED PERSON'S NAME: | | DATE OF BIRTH: | SEX: | SOC. SEC. # OR PT. ID #: |
| DATE OF DEATH: | TIME OF DEATH: | **PHYSICIAN OR NURSE PRACTITIONER EXPECTED TO SIGN MEDICAL CERTIFICATION OF DEATH:** | | |
| | | Name: | | Phone #: |
| **PERSON AUTHORIZING RELEASE TO FUNERAL ESTABLISHMENT OR RESPONSIBLE PERSON:** | | | | |
| Name: | | Phone #: | | Relationship to deceased person: |

**THE HUMAN REMAINS OF A PERSON WHO DIES UNDER ANY OF THE FOLLOWING CIRCUMSTANCES AS LISTED IN A.R.S. § 11-593(A) ARE REQUIRED TO BE REFERRED TO THE MEDICAL EXAMINER.**

**Did this person: (Check all that apply)**

☐ Die while not under the care of a physician or nurse practitioner for a potentially fatal illness
☐ Die and the attending physician or nurse practitioner is not available to sign the death certificate
☐ Die as a result of violence
☐ Die suddenly when in apparent good health
☐ Die in a prison
☐ Die while a prisoner
☐ Die in a suspicious, unusual or unnatural manner
☐ Die from a disease or an accident that may be related to the person's occupation or employment
☐ Die and may present a public health hazard
☐ Die during an anesthetic or surgical procedure
☐ NONE OF THE ABOVE

**WERE THE DECEASED PERSON'S HUMAN REMAINS REFERRED TO THE MEDICAL EXAMINER AS REQUIRED IN A.R.S. § 11-593?**
**YES** ☐ **NO** ☐ **N/A** ☐ **ME ACCEPTED** ☐ **ME RELEASED** ☐ **ME REFUSED** ☐

| **THE MOST RECENT DIAGNOSIS IN THE PERSON'S MEDICAL RECORD IS:** |
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Provide the following information if the deceased person's human remains are being released to: (1) A funeral establishment, (2) A person authorized under A.R.S. § 36-664 to receive the deceased person's communicable disease related information.

Indicate whether the deceased person had been diagnosed with or was suspected of having any of the following, as stated in the deceased persons medical record at the time of death. Please check all that apply:

☐ Infectious tuberculosis ☐ Creutzfeldt-Jakob disease ☐ Hepatitis C ☐ Other _____
☐ Human immunodeficiency virus ☐ Hepatitis B ☐ Rabies ☐ NONE

* For a death that occurs in a hospital: If the deceased individual's human remains have been accepted for donation by an organ procurement organization under A.R.S. Title 36, Chapter 7, Article 3, and the person authorized in A.R.S. §36-843 has not made or refused to make an anatomical gift, indicate whether the organ procurement organization has been notified that the deceased individual's human remains are being removed from the hospital. YES ☐ NO ☐

| **PERSON REPRESENTING THE HOSPITAL, NURSING CARE INSTITUTION, OR HOSPICE INPATIENT FACILITY WHO RELEASED THE HUMAN REMAINS** | | |
|---|---|---|
| Name (please print): | Signature: | Date: |
| **PERSON ACCEPTING THE HUMAN REMAINS** | | |
| Name (please print): | Signature: | Date & Time: |
| **FETAL DEATH INFORMATION** | | |
| Name of the Mother (please print): | Date of Delivery: | Estimated Gestational age or weight, if unknown: |

* This item is not required for nursing or in-patient hospice facilities.